MONTGOMERY COUNTY, MARYLAND

CHILD FATALITY *Review Team*

REPORT OF FINDINGS
1999 - 2000

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Background of Child Fatality Review

The circumstances that lead to each pediatric death should be carefully examined in order to determine whether there are any steps that can be taken to prevent similar tragedies. Currently, almost every state has a child fatality review process. These processes are generally multi-disciplinary, consisting of child advocates from many disciplines and professions who address the fatalities with a formal and systematic approach. The purpose of many of these teams is the prevention of future deaths through: investigation; data collection; system study; identification and implementation of changes to prevent future death; and service planning and provision. Certain issues must be considered when planning and implementing a child fatality team. These include the mission, causes of death and ages of children in cases to be reviewed, team structure (mandatory/optional members), confidentiality, communication, information sharing, and data collection (Kaplan, 1997).

What's Happening in Maryland?

Without legal mandate, Maryland established in 1988 a Child Fatality Review Team (CFRT) to examine unexpected and sudden deaths among children under age 15 (suicides are reviewed up to age 17) throughout Maryland. The source of the death data was the Maryland Chief Medical Examiner's Office (OCME). Annotated Code of Maryland, (Health – General) Section 5-309 requires a medical examiner to investigate all sudden, unexpected or unattended deaths occurring in Maryland (attachment A).

In April of 1999, the Maryland Legislature passed Senate Bill 464 and House Bill 958, defining the purpose of the State Fatality Review Team and outlining steps for achieving the team's goals. In addition, the legislation mandated a multi-disciplinary and multi-agency child fatality review team in each of Maryland's 24 political jurisdictions. The law defines the local teams' purpose as preventing child deaths by promoting cooperation among agencies, developing an understanding of the causes, developing plans, and advising the State of Maryland

The State Review Team has provided technical assistance to local jurisdictions, in an effort to encourage them to create their own multi-agency fatality review teams. Data from the local teams are reported to the state team for input into a statewide database.

Montgomery County's Team

Developed in 1997, the Montgomery County Child Fatality Review Team is comprised of individuals who either volunteer their time, or serve as a collateral duty of their employment. The team includes personnel from the following Montgomery County Department of Health and Human Services programs: public health, child protective services, emergency services, and mental health & addiction treatment services. Representatives of the County Police Department's Major Crimes and Youth Divisions, the County Fire & Rescue Service, the State Deputy Medical Examiner's Office, the State's Attorneys' Office, Montgomery County Public Schools, and Shady Grove Adventist Hospital's Sexual Abuse & Assault Center also serve as members. The team benefits from the diverse backgrounds and different perspectives of the members.

Montgomery County was the first county in Maryland to establish a multi-agency, multi-disciplinary team to review child deaths. In the interest of sharing its experience and knowledge, the team opens its meetings by invitation to guests from other counties who are establishing local review teams. At the team's invitation, other visitors occasionally attend meetings to provide additional consultation

or information about the circumstances of a particular death. All guests and members are required to sign a Confidentiality Agreement (attachment B) prior to the start of their first meeting.

As defined in its Statement of Purpose, the Child Fatality Review Team's mission is to:

§ achieve a better understanding of why and how children die in Montgomery County
§ improve the capacity of local agencies to prevent child fatalities
§ formulate recommendations that address the issues raised by child deaths
§ recommend system improvement strategies aimed at preventing child deaths and enhancing safety for all children.

Review Process

The team strives to meet monthly. However, staff availability and the number of cases received influence the frequency of meetings. Each month, the OCME sends the Montgomery County CFRT the *Maryland Child Fatality Review Case, Referral for Local Review* forms (attachment C), which lists the cases of deceased children. Upon receipt of the list, the Montgomery County Team Coordinator provides relevant team members information about the cases, so they can determine if the family or child was involved with their agencies. Team members bring all pertinent information to the meeting, where each case is discussed. After the review, the *Child Fatality Case* forms are completed and sent back to the OCME for inclusion in the statewide child fatality database. The local team records recommendations for short-and long-term prevention strategies related to each case (Attachment D).

In some case reviews, additional follow-up is warranted to learn more about the circumstances of the death. In this situation, follow-up is assigned to the team member who can most appropriately obtain the information, and the case is placed on the next meeting's agenda.

The Child Fatality Review Team uses the following definitions from the National Center for Health Statistics and the Maryland Division of Health Statistics, to classify the manner-of-death:

- Accidental: Death due to trauma that was an unforeseen outcome of a situation or behavior. Deaths due to accidents are unintentional and may or may not have been preventable. Nationally, public health professionals reject the term "accident" and instead use the term "unintentional injury". However, this document uses "accident" to maintain consistency with State Child Fatality Review definitions.
- Homicide: Death due to trauma* that was a direct result of a human action, whether with intent to injure or not.
- Suicide: Death due to self-inflicted trauma.* The deceased intended to harm him or herself.
- Natural: Death due to a biological cause, such as illness or congenital anomaly.

  Sudden Infant Death Syndrome (SIDS) is included in the *Natural* Death category by the OCME, but is separately identified with that category. *SIDS* is defined as the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history (Willinger, et al, 1991). A death is diagnosed as *SIDS* only after all other alternatives have been eliminated. *SIDS* is a diagnosis of exclusion.

- Undetermined: The manner of death cannot be determined with reasonable medical certainty.

**Trauma is defined as: 1) physical injury caused by violent or disruptive action; 2) introduction into the body of a toxic substance; and 3) unintentional and intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical or chemical energy or from the absence of such essentials as heat or oxygen (National Committee for Injury Prevention and Control, 1989).*

Analysis of Deaths

Montgomery County's team reviews the deaths of Montgomery County residents under 18 years of age that have been referred to the OCME. The team may choose to review the deaths of children who live elsewhere but whose deaths occur in Montgomery County. Occasionally, Montgomery County children die outside the county (for example, at Children's Hospital in the District of Columbia), and therefore are not referred to the OCME. A system to have information on these deaths sent automatically to the team has yet to be developed. The District of Columbia Medical Examiner's office has agreed to forward a copy of the autopsy report for $25.00. However, the team has no way to learn of these deaths except for media reports or informal notification that a Montgomery County child has died outside of the county.

This report covers the 23 deaths in 1999 and the 31 deaths in 2000 that were reviewed by the Montgomery County Child Fatality Review Team. Cases referred by the OCME to the team represent only a fraction of the total children's deaths. In 1999, 127 Montgomery County children under age 18 died, out of a total population of 207,170 children. Of these deaths, 86 children were under one year of age, with most of the deaths from natural causes. Only 23 of the 127 deaths were unexpected and evaluated by the CFRT. The increase in the number of cases reviewed in 2000 may be explained by the team's improved method of identifying cases to review and the variance in deaths from year to year.

Each fatality is analyzed for characteristics that may have contributed to the chain of events leading to the death of the child. The small number of yearly deaths may preclude identification of trends. However, the data may show trends over a period of several years. In addition, as teams are formed in other jurisdictions, statistics may be combined to show statewide or national trends. For these reasons, statistics are kept in the following areas:

- Manner of death
- Age at death
- Gender
- Race/ethnicity
- Location (house, car, school, street, etc.)

This report analyzes the above statistics for cases reviewed from 1999-2000. Cumulative statistics from the date the team started its reviews in May 1997 through December 2000 are located at the end of the report. The CFRT's recommendations to prevent child deaths, based on its analysis of reviewed cases, are discussed.

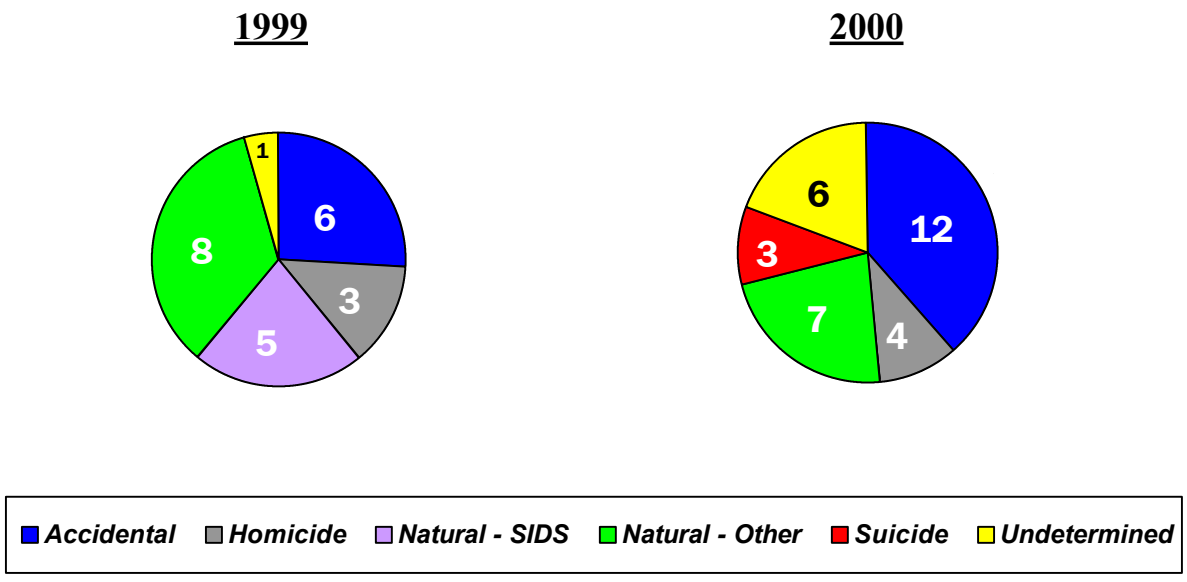
Manner of Death

1999

Incidents classified as *natural* were the most common manner of death, accounting for 13 of the 23 deaths. Five of these were classified as *SIDS*. Of the eight other children who died of *natural* causes, five died of infection, two of congenital defects, and one of hypoglycemia. There were six unintentional injuries: two were pedestrians, three were occupants in automobiles, and one was a bicyclist. *Homicide* was the next most common cause of death, accounting for three fatalities. In addition, one child died of asphyxiation due to an *undetermined* cause.

2000

The most common manner of death in 2000 was *accidental*, accounting for 12 of the 31 deaths. Motor vehicle crashes were the cause of 10 of these deaths. Of these 10, four children were not restrained; one was in a child safety seat; impaired drivers struck and killed two, and four motor vehicle-related deaths were alcohol-related. One child fell from a second-story window (through the window screen), and one died from cardiac arrhythmia related to a mishap while in a hospital. The second most common manner of death was *natural*, accounting for seven deaths. The variety of congenital, chronic and acute illnesses accounted for the *natural* causes. The manner of six deaths was *undetermined*, with four having the cause as *sudden unexpected death*. *Homicide* accounted for three deaths. Three adolescents committed *suicide*.



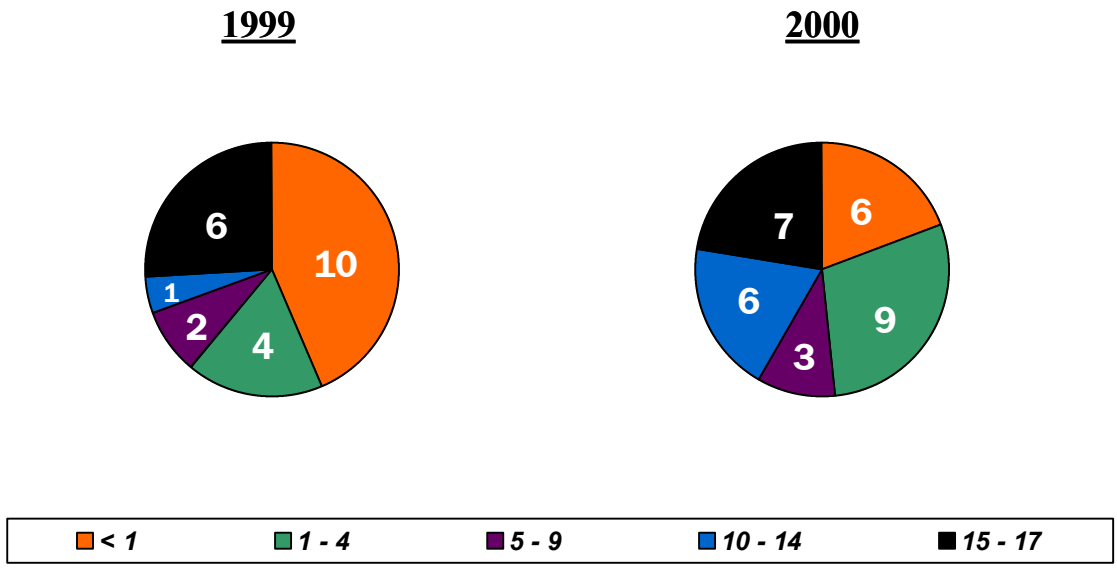
Age at Death

1999

The largest number of deaths (10) occurred among children under 12 months old. The deaths of five infants were attributed to *SIDS*, and five infants died in a *natural* manner (congenital conditions and infections). All three *homicides* occurred in the 1 – 4 age group; infection caused the other death in this age group. Among the 5 – 9 year old children, one death was due to infection, and one was a pedestrian struck. The only 10 – 14 year old child death was of an *undetermined* manner, but caused by asphyxiation. Among the 15 – 17 year olds, three were passengers in vehicles, one was a bicyclist, one was a pedestrian struck, and one died of congenital defects.

2000

The 1 – 4 age group accounted for the largest number of deaths (9). A window fall, a hospital misadventure, and a motor vehicle collision were reasons for the three *accidental* deaths. The manner of three deaths was *undetermined*, one was a *homicide*, and two were *natural*. Among the six infant deaths, two occurred in the neonatal period (<30days of age). Three infants died from *natural* causes and three deaths were of *undetermined* manner. The 5 – 9 age group incurred three deaths; two were in a motor vehicle crashes and one was a *homicide* victim. Of the 10 – 14 age group, three were *accidental* (MVA related), two were deemed to be *natural* (asthma and a cardiac disorder), and one was a *suicide*. The oldest group, 15 – 17 year olds, had seven deaths. Four were in automobile crashes, one was shot by a friend who mishandled the gun, and two committed *suicide*.



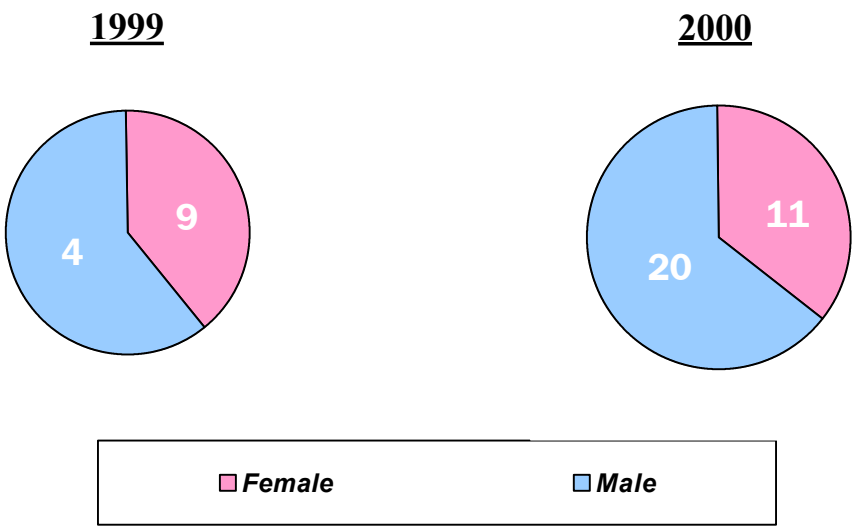
Gender

1999

Of the 23 deaths, 14 were males and nine were females. Of the five *SIDS* deaths, three were boys and two were girls. The manner of death was *natural (other)* for five girls and three boys. Two of the *homicide* victims were males, and one was female. Boys accounted for all six *accidental* deaths. The only undetermined death was a girl.

2000

The team reviewed 31 children's deaths in 2000. Twenty of these were male, and eleven were female. All six of the deaths under one year of age were males. No *SIDS* deaths were documented in the year 2000. A more limited definition of *SIDS* at autopsy may have contributed to this reduction. The manner of death was *natural (other)* for five boys and two girls. Two of the homicide victims were girls, and one was a boy. Of the *accidental* deaths, eight were boys and four were girls. All of the four 15 – 17 year olds whose deaths resulted from motor vehicle collisions were males. The three undetermined deaths were ????

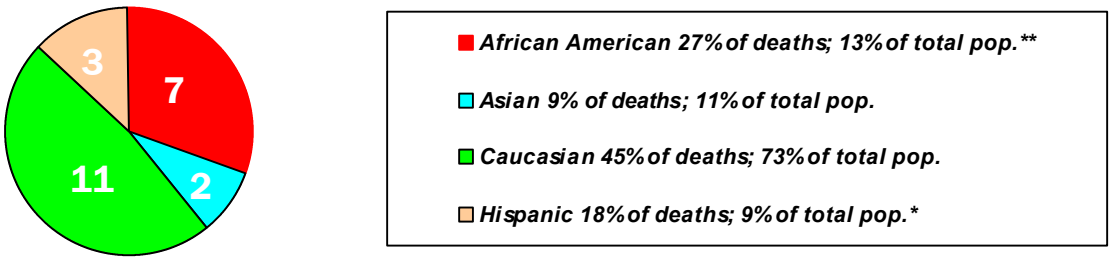


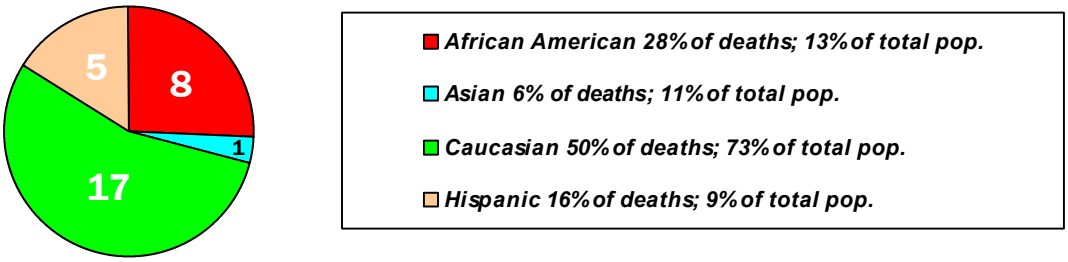
Race/Ethnicity

1999 Eleven of the deaths occurred among Caucasians, seven were African Americans, three were Hispanic, and two were Asians. Of the *SIDS* deaths, two were Caucasian, two were African American, and one was Hispanic. *Natural (other)* was the manner of death in four Caucasian children, two African-Americans children, one Hispanic child and one Asian child. Of the three homicides, two were African-American and one was Hispanic. Of the six *accidental* deaths, five were Caucasians and one was an Asian child.

2000

The largest number of deaths (17) occurred in the Caucasian population. Of these, eight were *accidental*, two were *natural*, two were *homicides*, two were *suicides*, and two were *undetermined*. The African American population incurred eight deaths: four *natural*, two *undetermined*, one *accidental*, one *homicide*, and one *suicide*. The team reviewed five Hispanic children's deaths. Three of these were *undetermined*, one was *accidental*, and one was *natural*. The only Asian fatality was a seven-year-old female involved in a motor vehicle collision



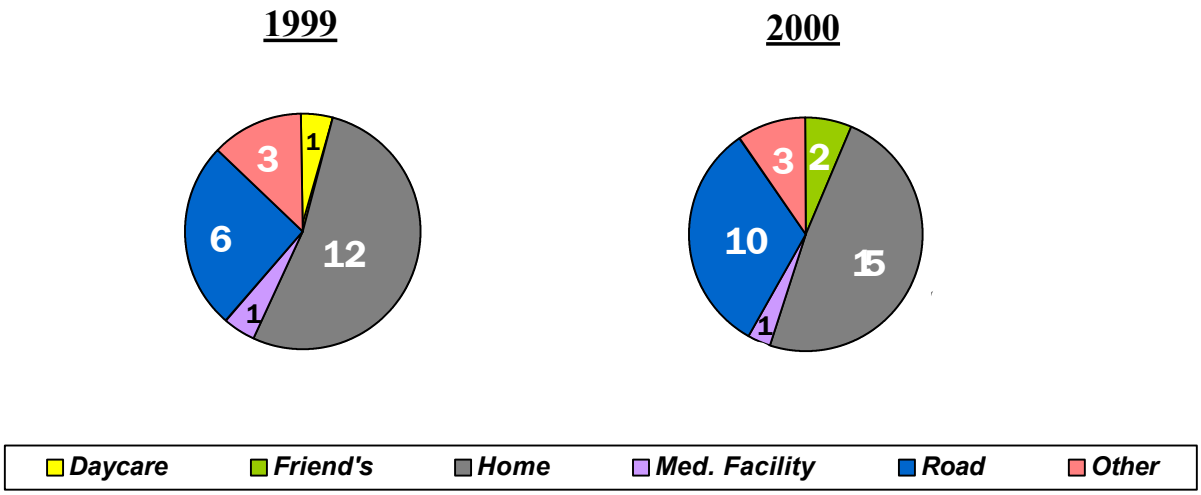


* Those of Hispanic origin may be of any race.

** Total population includes adults and children; statistics were not available solely on children

Location of Incident

In both years, the home was the most common place for a death to occur; the second most common location was a road.



Age & Manner

1999

	<1 YEAR	1-4	5-9	10-14	15-17
Accidental			1		5
Homicide		3			
Natural	10	1	1		1
Undetermined				1	
TOTAL	**10**	**4**	**2**	**1**	**6**

2000

	<1 YEAR	1-4	5-9	10-14	15-17
Accidental			1		5
Homicide		3			
Natural	10	1	1		1
Undetermined				1	
TOTAL	**10**	**4**	**2**	**1**	**6**

Race/Ethnicity & Manner

1999

	White	Black	Asian	Hispanic
Accident	5		1	
Homicide		2		1
Natural	6	4	1	2
Suicide				
Undetermined		1		
TOTAL	**11**	**7**	**2**	**3**

2000

	White	Black	Asian	Hispanic
Accident	8	1	1	1
Homicide	2	1		
Natural	2	4		1
Suicide	2	1		
Undetermined	2	2		3
TOTAL	**16**	**9**	**1**	**5**

Recommendations

The team continues to make recommendations for reducing pediatric deaths. However, the team does not have the resources to implement all recommendations, and lacks the authority to ensure implementation. The funding provided for injury prevention is not adequate in terms of the magnitude of the problem. In recognition of these limitations, the CFRT strives to integrate recommendations into existing programs and policies when possible.

This section includes details pertaining to the factors, both common and unique, to the deaths studied. Also included are recommendations for education, environmental modification, and enforcement. These recommendations may be used by anyone interested in injury prevention, including but not limited, to legislators, public safety personnel, health care workers, child-care providers, and grass roots coalitions.

General Recommendations

- Encourage vigilant supervision of children
- Address cultural issues pertaining to child safety

Motor Vehicle - Related Injuries

Motor vehicle related injuries accounted for all six *accidental* deaths in 1999 and 10 out of 12 in 2000. A Frederick County child who died in a 2000 Poolesville crash and a Montgomery County child who died in Howard County are included in this report. In addition, an out-of-state teen, who was killed in a 1999 Montgomery County crash while riding with a local youth, is also included.

Montgomery County's data reflect national and Maryland trends, with motor vehicle-related death ranking as the leading cause of unintentional childhood deaths. Contributing to the motor vehicle deaths are the issues of drivers impaired by 1alcohol/drugs, inattention, unrestrained occupants, young drivers, bicycle and pedestrian safety, unattended children in vehicles, and environmental factors.

Recommendations – Motor Vehicle-Related Injuries

- Support safety legislation in the 2002 Maryland General Assembly
- Consider merits of legislation that address inattention while driving
- Identify and correct road hazards and *high risk* roadways to make design changes, such as adding rumble strips.

Impaired Driving

Alcohol was implicated in six out of ten motor vehicle related deaths in 2000, but not in any of the 1999 deaths. Some children were hit by impaired drivers, some were driving under the influence, and some were passengers in vehicles driven by impaired drivers. Effective strategies have been identified to reduce impaired driving.

Recommendations – Impaired Driving

- Support county programs, such as *Drawing the Line,* and police alcohol enforcement efforts to reduce incidence of impaired driving, especially among teens
- Revitalize Mothers Against Drunk Driving (MADD) in Montgomery County
- Support promising new approaches to reduce underage drinking, such as a geographically targeted, server training programs
- Support legislation to hold impaired drivers accountable for their actions

Occupant Restraints

During the two-year period 1999-2000, 13 children were killed while riding as occupants in motor vehicles. Of these children, eight were not restrained. While restraint use will not save every child, the proper use of restraints greatly increases the chance of survival. The use of safety seats and seat belts continues to be a priority in combating traffic fatalities and injuries. Montgomery County conducts one of the leading child passenger safety (CPS) programs in the United States. The program has received national acclaim, and can documented nine lives saved through safety seat checks and safety seat distribution programs for low-income families. However, continuous change in the parent population and difficulties reaching those at high risk continue to pose challenges for CPS programs.

Recommendations – Occupant Restraints

- Maintain and expand child passenger safety programs
- Focus attention on booster seat and safety belt use by children and adolescents through a public awareness campaign, education and enforcement
- Consider dedicating state Medicaid funds to provide child safety seats to eligible families
- Support legislation mandating booster seat use up to and including eight years and eighty pounds

Young Drivers

Novice drivers and their passengers are at high risk for traffic-related injuries. Of the 13 motor vehicle occupants killed in the two-year period1999-2000, seven were either young drivers or the passengers of a young driver. Inexperience, speed, and the presence of passengers are all factors that contribute to this increased risk. Graduated licensing requirements recently enacted in Maryland should help novice drivers gain skills over a longer time period before receiving an unrestricted drivers license and should, therefore, reduce the death/injury rates of this group. Open lunch periods

at school present an additional risk factor of time pressure for inexperienced drivers, who frequently transport other students to food establishments off-campus.

Recommendations – Young Drivers

- Encourage parents/guardians to provide more supervision of young drivers than currently required by law.
- Encourage school policies such as on-campus lunch, which will reduce the need for student driving
- Discourage young drivers from transporting passengers

Pedestrians

In 1999, 20 pedestrians died in Montgomery County; two of these deaths were children. Montgomery County, as a whole, has experienced a surge of pedestrian deaths in the last few years. The county has responded by establishing a panel to examine the pedestrian problem and to make recommendations to lower pedestrian injuries and deaths. Although the vast majority of pedestrian deaths in the county were adults, the findings of this panel should also impact the pedestrian deaths and injuries of children. In addition, sidewalk snow removal legislation recently signed into county law should help reduce injuries by allowing pedestrians to remain on the sidewalk rather than being forced to walk on streets made impassable by snow accumulation.

Recommendations - Pedestrians

- Support measures to increase the safety of pedestrians, including:
  1. Expanding *Walk Your Child to School Day* to alert the community to needed changes along school routes
  2. Increasing the number of red light cameras
  3. Improving the timing of walk lights
  4. Implementing the Maryland Pedestrian Safety Fund to facilitate local jurisdiction pedestrian programs
  5. Supporting legislation to toughen laws related to greater pedestrian safety
  6. Enforcing jaywalking laws

Bicycles

One child died on a bicycle in 1999. The CFRT identified some common factors in the circumstances surrounding three children's fatal bicycle crashes during the period from 1997 to 1999. All three victims were young adolescents, all crashes involved motor vehicles, no victims were wearing bicycle helmets, two crashes occurred at dusk, and two were the fault of the motorist. These commonalties suggest opportunities for prevention strategies. Young adolescents often resist wearing bicycle helmets, yet confidence in their cycling skills may increase their exposure to complex traffic situations and put them at high risk for injury.

Recommendations – Bicycle Safety

- Support bicycle safety programs and safety fairs that include education regarding helmet use and rules of the road
- Design/implement an age-appropriate bike safety program for young adolescents
- Support road design and bicycle trails that enable safe cycling

Other Accidental Deaths

The medical examiner's office assigned an *accidental* manner of death to two Montgomery County children that were not killed as a result of a motor vehicle-related injury. A window fall and a cardiac arrhythmia associated with a hospital misadventure were causes of these deaths. Falls are very common in childhood and account for many Montgomery County children's admissions to our trauma center. However, very few result in death.

Recommendations – Accidental Deaths

- Support home safety program
- Encourage parents and care givers of young children to install window guards on all windows (ensuring that such guards can be opened in the event of a fire)

Natural Deaths (Not SIDS)

Natural deaths suggest perceived barriers to primary care in some, but not all, instances. Some children's medical conditions appear to have been well managed, yet a mild condition progressed very rapidly and led to the child's death. In other deaths, it was unclear if the child's condition was recognized as serious and managed properly. Some deaths were clearly not preventable. Cardiac abnormalities accounted for two sudden deaths of a-symptomatic adolescents. Asthma-related complications were implicated in two other cases. There was no telephone in the home of one low-income, chronically ill child when she was stricken. The family had to run to a near by fire station for help.

Recommendations

- Support programs for families who have children with chronic illness
- Support community efforts to reduce the incidence of asthma attacks and to ensure proper management
- Ensure that all children have access to health care and available resources are utilized
- Encourage anticipatory guidance to alert parents of age-appropriate risks to children
- Ensure that all families with a chronically ill child have telephone access to emergency response (replicate cell phone distribution program similar to the one established for domestic violence)

Sudden Infant Death Syndrome (SIDS)

The apparent substantial decline in *SIDS* deaths may be partially attributed to a real reduction, but also to a more limited and precise definition of *SIDS* at autopsy. In 1999, *SIDS* accounted for five infant deaths. There were no *SIDS* deaths in 2000; however, six infant deaths were of *undetermined* manner and the cause was given as unexplained sudden infant death. Many of the babies who died in 1999 and 2000 were bed-sharing with family members.

Team concerns about the frequency of unsafe sleeping practices identified in the circumstances surrounding infant deaths led the team to sponsor a survey on baby sleeping issues in early 2000. Of the 307 people surveyed, 56% were aware of the need to place a baby on its back to sleep (see appendix for report). Key priorities for continuing to reduce *SIDS* deaths include educating parents and caretakers on the importance of safe sleeping practices and safe cribs.

Recommendations - SIDS

- Expand a *Safe Sleeping* awareness campaign in Montgomery County
- Provide needy families with access to affordable cribs that meet current safety standards

Homicides

During the 1999-2000 period, the medical examiner ruled homicide the manner of six children's deaths. One of these children had been killed several years earlier; however, the date of death was recorded in 2000, the year the body was found. All childhood deaths are disturbing, but homicides are particularly troublesome. An adolescent was shot by another teen who was mishandling a gun. Another child was the victim of a murder-suicide, and caregivers were implicated in the deaths of two children. One young child died of hyperthermia when left in a locked, hot car.

Alarmed by an increase in complaints of children left unattended in cars, Montgomery County instituted a public awareness campaign to reduce the occurrence. Child welfare officials were not only concerned about the health risks posed to a child left in a car, but also the child's safety if the car was stolen. An education campaign began in April 2001to make parents aware that it is unsafe and illegal to leave children alone in a car. The County also began a *handgun safety awareness campaign* by passing safety lock legislation in 1998 and distributing safety locks and educational materials.

Recommendations - Homicide

- Promote safe gun storage for firearms and ammunition
- Support public awareness of the danger of children left unattended in motor vehicles
- Alert the public on how and when to report suspected abuse or neglect

Suicides

The risk of teen suicide remains a reality. Depression, mixed with impulsive actions, can have tragic consequences. In 2000, three adolescents committed suicide in Montgomery County, and none in 1999. Hanging was the cause in two deaths and an overdose of medication in the other.

Recommendations - Suicide

- Identify early symptoms of depression
- Treat adolescents promptly
- Encourage safe firearms storage
- Encourage parents to be cognizant of changes in their children

Undetermined

The number of *undetermined* deaths rose from one in 1999 to six in 2000, probably due to a more limited diagnosis of *SIDS* at autopsy. In two of the *undetermined* cases, the team was able to gain insight into the most likely cause and manner of death. The team's conclusions were based on a review of death-related records and consultations with medical specialists.

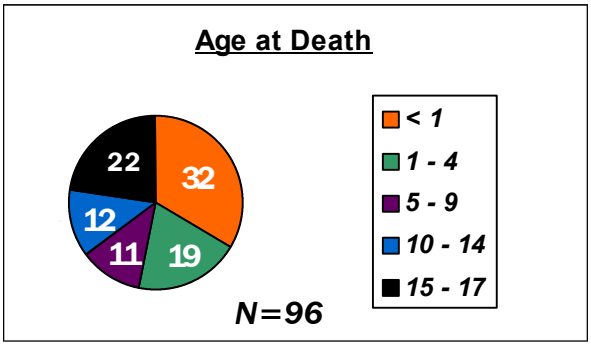
Future Plans

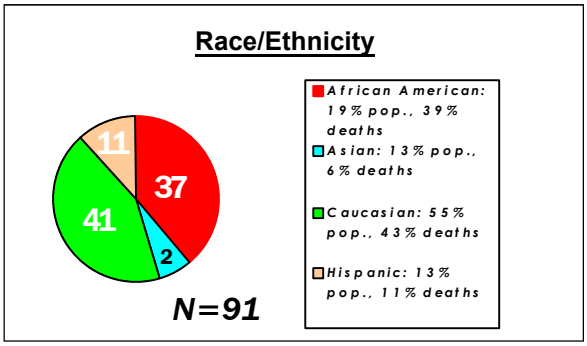
As the database of Montgomery County cases increases, and as more jurisdictions develop Child Fatality Review Teams, it may be possible to identify trends in child fatalities. Additionally, Montgomery County rates could be compared with those of other jurisdictions and with the State of Maryland. Beginning with the year 2002, all child deaths in the county (including those that occur due to illness or genetic causes) will be reviewed quarterly. However, the team will not apply the same detailed methods of examination to these cases that it employs with OCME cases. Discussions are ongoing to examine the feasibility of expanding the caseload to include near-deaths. The lack of a method for gathering data regarding these incidents, and the substantial increase in caseload that is anticipated if near-deaths are included, currently precludes these cases from being investigated by the team.

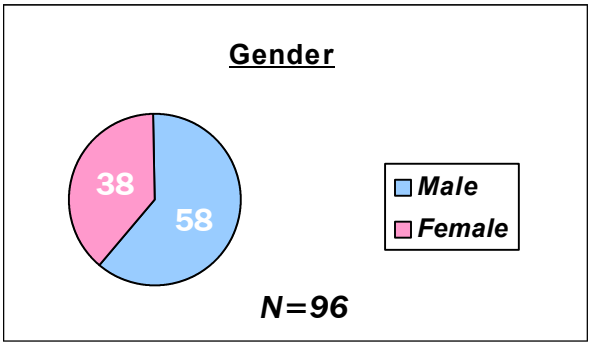
Children under one year of age experience a higher death rate than any other pediatric age group. This age group also shows a large disparity between African American and Caucasian children. To ensure that no details are overlooked, the County has established a more thorough process for reviewing the deaths of all children under one year of age than that which was previously used. This combines the approaches of two teams – the Child Fatality Review Team, and the Fetal and Infant Mortality Review (FIMR) Team. A liaison has been appointed to coordinate this process.

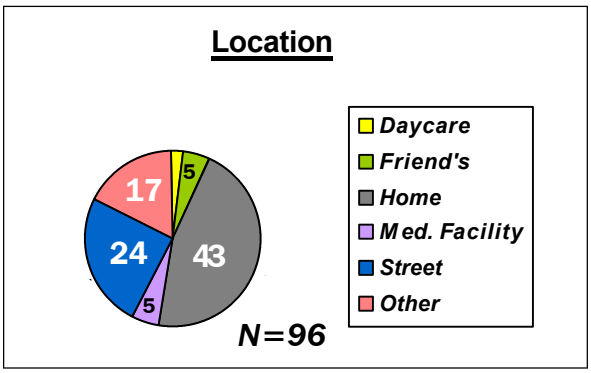
The team will work to improve its data collection system. As the number of cases reviewed increases, it will be especially important to easily retrieve pertinent information and to conduct statistical analyses. This will require an investment of time in 2002 to design a system and input all of the data going back to May 1997, but it is a critical element in the review process.

1997- 2000 Statistics









MANNER OF DEATH

NATURAL	**38**
SIDS	16
Infection	9
Cardiac abnormality	6
Other	7
ACCIDENTAL	**30**
MVA – Occupant	20
MVA – Pedestrian	2
Bicyclist	3
Drowning	3
Other	2
HOMICIDE	**16**
SUICIDE	**4**
UNDETERMINED	**8**
TOTAL	**96**

* Those of Hispanic origin may be of any race.

** Population percentages based on 1999 population estimates.

*** Deaths reviewed are ages 0 – 17, and population data is age 0 – 18.

Article 5-309 of the Annotated Code of Maryland
Article - Health - General - § 5-309

(a) (1) A medical examiner shall investigate the death of a human being if the death occurs:

(i) By violence;

(ii) By suicide;

(iii) By casualty;

(iv) Suddenly, if the deceased was in apparent good health or unattended by a physician; or

(v) In any suspicious or unusual manner.

(2) A medical examiner shall investigate the death of a human fetus if:

(i) Regardless of the duration of the pregnancy, the death occurs before the complete expulsion or extraction of the fetus from the mother; and

(ii) The mother is not attended by a physician at or after the delivery.

(b) If a medical examiner's case occurs, the police or sheriff immediately shall notify the medical examiner and State's Attorney for the county where the body is found and give the known facts concerning the time, place, manner, and circumstances of the death.

(c) Immediately on notification that a medical examiner's case has occurred, the medical examiner or an investigator of the medical examiner shall go to and take charge of the body. The medical examiner or the investigator shall investigate fully the essential facts concerning the medical cause of death and, before leaving the premises, reduce these facts and the names and addresses of witnesses to writing, which shall be filed in the medical examiner's office.

(d) The medical examiner or the investigator shall take possession of and deliver to the State's Attorney or the State's Attorney's designee any object or article that, in the opinion of the medical examiner or the investigator, may be useful in establishing the cause of death.

(e) (1) If the next of kin of the deceased is not present at the investigation, the police officer or sheriff at the investigation or, if a police officer or sheriff is not present, the medical examiner or the investigator shall:

(i) Take possession of all property of value found on the body;

(ii) In the report of the death, make an exact inventory of the property; and

(iii) Deliver the property to the appropriate sheriff or police department.

(2) The sheriff or police department shall surrender the property to the person who is entitled to its possession or custody.

(f) If the case involves the unexpected death of a child, the medical examiner shall notify the chairperson of the local child fatality review team for the county in which the child resided.

MONTGOMERY COUNTY, MARYLAND

MONTGOMERY COUNTY MULTI-DISCIPLINARY CHILD FATALITY REVIEW TEAM

Confidentiality Agreement

The Child Fatality Review is a confidentlal process. Surviving family members or caregivers, service providers and providing agencies are to be protected from disclosure of information outside of the review meetings. The Annotated Code of Maryland, Article 88A, Section 6 (Misuse of public assistance lists and records) specifically applies.

In addition, the nature of the review meeting is designed to encourage free discussion and exploration of issues. Participants may express opinions which do not necessarily reflect their agency position, or which they later change. Some factors discussed will be sensitive: many will involve matters of values and beliefs or may concern cultural variables. In order for there to be a free exchange of differing ideas and for an atmosphere of communication among different agencies and representatives to develop, it is important that opinions expressed are not repeated outside of the meeting, nor used to express judgments about an individual, an agency or a profession.

Therefore, as a participant or observer of the Montgomery County Multi-Disciplinary Child Fatality Review Team proceedings, I agree to abide by the following:

- I will refrain from discussing cases outside of the meetings, except in very general terms or on a "need to know" basis with other Team members.
- I will refrain from speculation about the decedent, family members, caregivers, providers or institutions in connection with any case.
- I will respect the opinions of those speaking at the meeting, while being willing to voice disagreement and engage in dialogue in a professional manner which keeps any disagreement within the meeting.
- Outside of the meeting, I will discuss only the general work of the Child Fatality Review Team and the kinds of issues that It addresses. I will not represent to the public, the media, professional audiences or anyone else any finding or recommendation unless final approval for my doing so has been obtained from the Team.
- I will carry back to my own institution, agency or community ideas which may assist in a better understanding of child deaths, preventive activities and improved delivery of services, within the limits expressed above.

_____ _____

Name *Witness*

_____

Position

_____

Date

MONTGOMERY COUNTY
CHILD FATALITY REVIEW TEAM

Membership

Kathy Wood, R.N., Co-Chair
Montgomery County Department
of Health and Human Services
Public Health Services

Donna Seeyle, R.N. SANE, Co-Chair
Coordinator, Sexual Abuse and
Assault Center
Shady Grove Adventist Hospital

Sue Dudley, Coordinator
State's Attorney's Office
Judicial Center

Karen Riibner - Coordinator
Montgomery County Department
of Health and Human Services
Addiction Services

Barbara Bonnin, LCSW -C
Montgomery County Department
of Health and Human Services
Children, Youth and Families
Child Welfare Services

Laura Chase
Montgomery County
State's Attorney's Office
Judicial Center

Sheila Dennis, LCSW -C
Montgomery County Department
of Health and Human Services
Children, Youth and Families
Child Welfare Services

Narita Estampador-Ulep, M.D., F.A.A.P.
Physician/Child Protection Services
and Community
School Health Services
Montgomery County Department
of Health and Human Services

Captain Barney Forsythe
Montgomery County Police Department
Major Crimes Division

Carol W. Garvey, M.D.
Health Officer
Montgomery County Department
of Health and Human Services

Lt. Anne Harrison
Montgomery County Department
of Fire and Rescue Services
Executive Office Building, 12th Floor

Det. Winnie Johnson
Montgomery County Police Department
Family Services Division

Min Leong
Student Services
Montgomery County Public Schools

Beverly Byron
Public Health Services
FMR

Lorne K. Garretson, M.D., F.A.A.P.
Professor Emeritus Emory University
Department of Pediatrics

Brenda C. Petersen
Health Care Coordinator
Montgomery County Department
of Health and Human Services

Dr. C. Margolis - Deputy Medical Examiner
Montgomery County Maryland